Sexual Misconduct

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In this guide

Sexual misconduct is unwelcome behaviour of a sexual nature. It can be physical, verbal, visual or online. It could be a pattern of behaviour or a single incident.

Sexual harassment will also amount to sexual misconduct. Sexual harassment is unwanted conduct which violates dignity or creates an intimidating, hostile, degrading, humiliating or offensive environment and which is of a sexual nature.[1] Conduct could have this effect, and therefore amount to harassment, even where that was not the intention. In cases of this kind, the focus will be on the impact of the behaviour. Other forms of harassment, including that relating to protected characteristics, is discussed in our misconduct guidance.

Sexual misconduct in the workplace

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In the workplace sexual misconduct will include not only sexual harassment but also any sexualised behaviour towards those receiving care or their family members. The Professional Standards Authority's guidance on sexual boundaries explains why sexualised behaviour of this kind is unacceptable:

> "Healthcare professionals must not display sexualised behaviour towards patients or their carers. This is because the healthcare professional/patient relationship depends on confidence and trust. A healthcare professional who displays sexualised behaviour towards a patient or carer breaches that trust, acts unprofessionally, and may, additionally, be committing a criminal act. The abuse of patients is also highly damaging in terms of confidence in healthcare professionals generally and leads to a diminution in trust between patients, their families and healthcare professionals."

Sexual misconduct against people receiving care (including sexualised behaviour) or against colleagues poses a significant risk to the quality of care people receive and public confidence in the nursing and midwifery professions.

Sexual misconduct against a person receiving care can have long lasting personal and mental health impacts. It also damages public confidence in the profession and makes people more reluctant to receive care or discuss sensitive matters with professionals. In any case relating to sexual misconduct against a personal receiving care, decision makers should carefully consider how the power dynamic between the professional and the circumstances of the person receiving care may create vulnerability.[2] In addition to this, any sexual misconduct against children or will always pose significant risks to the safety of the public and public confidence in the profession.

Example:

Example 1

The Fitness to Practise Committee finds that a nurse had a consensual sexual relationship with a patient they see regularly for asthma reviews. The patient is not a vulnerable adult, as they are able to take care of themselves and protect themselves. However, from their discussions at the asthma reviews, the nurse knows that the patient is isolated and struggles with their mental health. The considers the vulnerability factors, i.e. the professional-patient relationship and the patient's isolation as an aggravating factor. It finds that the relationship amounts to misconduct and makes a finding of impairment resulting in regulatory action.

Sexual misconduct between colleagues

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Sexual harassment harms the dignity of colleagues and may cause a harmful workplace culture, or one where professionals are unable to express their clinical judgment or raise concerns. This creates a risk to public safety. More broadly, any form of sexual harassment in the workplace can harm public confidence in the profession.[3]

Cases of sexual misconduct between colleagues pose a particular risk to public confidence in the profession and to public safety where there are elements of abuse of power or manipulation. This is because such cases undermine the level of trust that can be placed in senior professionals. It could also affect the quality of training or breadth of experience received by junior colleagues if they are reluctant to work with senior professionals for fear of how they will behave. This will pose a danger to the health, safety and wellbeing of the public unless the conduct is unlikely to be repeated.[4]

Example:

Example 2
A senior midwife acts as a preceptor to a junior colleague. At a team social, the preceptor inappropriately touches the junior colleague. When she tries to move away, the preceptor suggests this is part of her 'training' and that the preceptor may need to re-evaluate whether to sign off the preceptorship period.

The Committee finds that this amounts to misconduct, and that the power imbalance between the midwife and junior colleague and the suggestion of manipulation poses a significant risk to junior midwives' training and public confidence in the profession.
The Professional Standards Authority has also produced research on sexual misconduct between colleagues highlighting the negative impacts that this kind of behaviour can have on public safety and the quality of care.

Sexual misconduct outside the workplace

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In our guidance on behaviour outside of professional practice [LT8.1]we say that we will take action when a professional's conduct:

- could pose a risk to our public protection objectives, including risks to public safety, public confidence in the profession or professional standards, or
- raises fundamental questions about the professional's ability to uphold the values and standards set out in the Code.[5]

Sexual misconduct outside professional practice could indicate deep-seated attitudinal issues which could put the public at risk. It may also raise fundamental questions about the professional's ability to uphold the standards and values set out in the Code. As such, sexual misconduct outside the workplace could require us to take regulatory action.

Example:

Example 3
A referrer alleges that her neighbour, a registered nurse, has propositioned her on a number of occasions in a way that she considers to be sexually explicit and demeaning. The professional accepts that he made the comments, but stated that he was trying to flirt with his neighbour and had misunderstood their relationship.

Depending on what exactly was said, this is unlikely to amount to sexual misconduct. While potentially inappropriate, the alleged incidents would not affect public confidence in the profession or put the public at risk of harm. However, if it transpired that the nurse had used discriminatory, misogynistic or threatening language, or had continued to proposition his neighbour after she had made clear that his behaviour was not welcome, we may need to consider the matter further.

Example 4
The police tell us about a professional sharing explicit sexual fantasies about young children in online forums. The professional has admitted to making these posts. The police are not pursuing the matter because there is no evidence of child sexual abuse and therefore no crime had been committed.

While the messages were sent outside of work, they appear to suggest a sexual interest in children which could pose a risk to the public in the course of professional practice. Such expression could also seriously undermine public trust and confidence in the profession. This concern could amount to misconduct and a finding of impairment, and is likely to result in regulatory action.

Sexual motivation

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Not all sexualised language or behaviour is sexually motivated; it may be intended as an exercise of power or to cause distress or discomfort. For example, it could be part of bullying, harassing or discriminatory behaviour. It may also come from an unprofessional culture in the workplace.In those cases we'll consider the impact of the unprofessional conduct on colleagues or other members of the public. We may consider that regulatory action is still necessary, despite there being no clear sexual motivation. However, we should always take into account the context in which the misconduct arose.

Drafting regulatory concerns and charges relating to sexual misconduct and sexual motivation

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In all cases relating to sexual misconduct, we should ensure that we are as specific as possible about what happened, and state clearly whether the misconduct was "sexual" in nature.

When we are drafting charges, we should consider whether sexual motivation should be separately charged. This is because sexual motivation may make the charges more serious; the professional needs to understand what is alleged to defend themselves,[6] and the Committee may need to consider the alleged motivation at sanction stage.[7] By sexual motivation, we mean what happened was done either for sexual gratification or looking for a sexual relationship.[8] It may be appropriate for the charge to state that the conduct was both "sexual" in nature and sexually motivated. Our decision should always depend on the facts of the particular case.

We may not need to charge that an act was sexual or sexually motivated separately if the alleged misconduct is clearly sexual in nature. This is because it will already be obvious to everyone involved.[9] An example might be if the professional touches a patient's genitals without any clinical reason or slaps their bottom. However, we should always consider carefully whether the nature of the act or the motivation would have been clear to everyone in that situation.

We may sometimes need to be explicit in regulatory concerns and charges if we consider the behaviour was predatory or deliberately targeted, so that everyone involved understands the seriousness of the concerns.

Where sexualised language or behaviour may not be sexually motivated, but is part of bullying, harassing or discriminatory behaviour, we'll consider whether the motivation is likely to be a serious aggravating factor and should be specifically alleged in the charges.[10]

Consent

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Depending on the charges presented to a panel, we may need to consider whether the alleged victim consented to the activity that took place. However, it is important to note that in some cases consent may not affect whether or not misconduct took place. For example, if a person receiving care consented to a relationship with a professional providing them with care, this would still amount to misconduct.

Where the panel needs to consider consent, they must consider both whether the alleged victim consented, including whether they had the capacity to consent, and whether the professional reasonably believed that the alleged victim consented. When considering whether the professional reasonably believed there was consent, the panel must consider all the relevant circumstances. This will include what the professional did to confirm whether or not the alleged victim consented.[11] Panels may need to consider whether the alleged victim was unable to consent because they were

drunk, drugged or unconscious.

Myths and stereotypes

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When making decisions in cases about sexual misconduct, panels should be mindful of the myths and stereotypes surrounding rape and other forms of sexual misconduct, as well as their own biases. Panels should take account of the CPS guidance in this area and should ensure that their reasoning is not influenced by these common myths and stereotypes. While the CPS guidance refers only to rape, the sections referring to context and how people react to rape are likely to apply to any non-consensual sexual activity.

1. Section 26 Equality Act 2010
2. Professional Standards Authority for Health and Social Care v General
3. Medical Council and Onyekpe [2023] EWHC 2391 (Admin), paragraphs 91 and 93
4. Arunachalam v General Medical Council [2018] EWHC 758 (Admin)
5. PSA v GMC and Hanson [2021] EWHC 588 (Admin)
6. Sait v GMC [2018] EWHC 3160 (Admin)
7. CRHCP v GMC and Rajeshwar [2005] EWHC 2973 (Admin)
8. Basson v General Medical Council [2018] EWHC 505 (Admin)
9. GMC v Haris [2020] EWHC 2518)
10. PSA v HCPC and Yong [2021] EWHC 52.
11. Section 1 Sexual Offences Act 2003